		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021568

Facility Name: The Elms

Address: 1212 Madelyn Avenue (Number) Macomb (City) 61455 (Zip Code)

County: McDonough

Telephone Number: (309) 837-5482 **Fax #** (309) 833-1054

HFS ID Number: 37-6001537001

Date of Initial License for Current Owners: 10/11/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles Ackers **Telephone Number:** (309) 837-5482

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/04 to 11/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Charles Ackers
(Title) Administrator

Paid Preparer

(Signed) See Attached Accountant's Report (Date)
(Print Name and Title) John Lehman, Partner
(Firm Name & Address) Clifton Gunderson LLP, 301 SW Adams,Suite 900,P.O.Box 1835 Peoria,IL 61656-1835
(Telephone) (309) 671-4500 Fax # (309) 671-4508

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 98

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		1,606	1,418	3,024	8
9	SNF/PED					9
10	ICF	23,153	8,279		31,432	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,153	9,885	1,418	34,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.33%

D. How many bed-hold days during this year were paid by the Department? 187 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/11/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 1,418

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: 11/30/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	275,565	21,407	5,979	302,951		302,951	(166)	302,785			1
2	Food Purchase		169,741		169,741		169,741	(2,828)	166,913			2
3	Housekeeping	143,171	18,941	1,292	163,404		163,404		163,404			3
4	Laundry	57,719	54,218	99	112,036		112,036		112,036			4
5	Heat and Other Utilities			88,132	88,132		88,132		88,132			5
6	Maintenance	71,498	18,001	16,056	105,555		105,555	20,388	125,943			6
7	Other (specify):* **Waste Removal**			6,867	6,867		6,867		6,867			7
8	**TOTAL General Services**	547,953	282,308	118,425	948,686		948,686	17,394	966,080			8
	B. Health Care and Programs											
9	Medical Director			360	360		360		360			9
10	Nursing and Medical Records	1,611,715	182,149	8,875	1,802,739		1,802,739	(27,431)	1,775,308			10
10a	Therapy	101,374		67,539	168,913		168,913		168,913			10a
11	Activities	98,405		11,781	110,186		110,186		110,186			11
12	Social Services	62,416		1,146	63,562		63,562		63,562			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,873,910	182,149	89,701	2,145,760		2,145,760	(27,431)	2,118,329			16
	C. General Administration											
17	Administrative	69,112			69,112		69,112		69,112			17
18	Directors Fees											18
19	Professional Services			13,440	13,440		13,440		13,440			19
20	Dues, Fees, Subscriptions & Promotions			15,789	15,789		15,789	(3,619)	12,170			20
21	Clerical & General Office Expenses	118,773	9,631	41,487	169,891		169,891	(21,747)	148,144			21
22	Employee Benefits & Payroll Taxes			736,545	736,545		736,545	333,413	1,069,958			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,608	2,608		2,608		2,608			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							26,845	26,845			26
27	Other (specify):*											27
28	**TOTAL General Administration**	187,885	9,631	809,869	1,007,385		1,007,385	334,892	1,342,277			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,609,748	474,088	1,017,995	4,101,831		4,101,831	324,855	4,426,686			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Elms #0021568 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			146,796	146,796		146,796		146,796			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			146,796	146,796		146,796		146,796			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,604	52,604		52,604		52,604			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			52,604	52,604		52,604		52,604			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,609,748	474,088	1,217,395	4,301,231		4,301,231	324,855	4,626,086			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,828)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,684)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,536)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,734)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,419)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(45,036)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,237)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	395,092	6,22,26,32	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 395,092		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 324,855		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

The Elms

ID# 0021568

Report Period Beginning: 12/1/04

Ending: 11/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Food Service Reimbursement	$ (166)	1	1
2	Pop and Vending	(16,476)	21	2
3	Nursing Reimbursement	(27,431)	10	3
4	Clerical and General Office	(587)	21	4
5	Employee Benefit Reimbursement	(176)	22	5
6	Macomb Chamber of Commerce	(200)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(45,036)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number The Elms **#** 0021568 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(166)	0	0	0	0	0	0	0	0	0	0	(166)	1
2	Food Purchase	(2,828)	0	0	0	0	0	0	0	0	0	0	(2,828)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	20,388	0	0	0	0	0	0	0	0	0	20,388	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,994)	20,388	0	0	0	0	0	0	0	0	0	17,394	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(27,431)	0	0	0	0	0	0	0	0	0	0	(27,431)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(27,431)	0	0	0	0	0	0	0	0	0	0	(27,431)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,619)	0	0	0	0	0	0	0	0	0	0	(3,619)	20
21	Clerical & General Office Expenses	(21,747)	0	0	0	0	0	0	0	0	0	0	(21,747)	21
22	Employee Benefits & Payroll Taxes	(3,910)	337,323	0	0	0	0	0	0	0	0	0	333,413	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	26,845	0	0	0	0	0	0	0	0	0	26,845	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,276)	364,168	0	0	0	0	0	0	0	0	0	334,892	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,701)	384,556	0	0	0	0	0	0	0	0	0	324,855	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **The Elms** **# 0021568** **Report Period Beginning:** **12/1/04** **Ending:** **11/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,536)	10,536	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,536)	10,536	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(70,237)	395,092	0	0	0	0	0	0	0	0	0	324,855	45

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				McDonough County	Macomb, IL	Local Gov't Unit
				Macomb Public Bldg.		
				Commission	Macomb, IL	Local Gov't Unit

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	$	Macomb Public Building Commission	N/A	$ 20,388	$ 20,388	1
2	V	22	Employer's Share of IMRF and FICA		McDonough County	N/A	337,323	337,323	2
3	V	26	Property and Liability Insurance		McDonough County	N/A	26,845	26,845	3
4	V	32	Interest		Macomb Building Commission	N/A	9,950	9,950	4
5	V	32	Interest-Amortization of Bond Costs		Macomb Building Commission	N/A	586	586	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 395,092	$ * 395,092	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Not Applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Macomb Public Building	X		Expansion of Facility		12/1/93	$ 450,000	$ 162,900	2/1/09	.0400 to	$ 9,950	1
2	Commission Bonds									0.0575		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 450,000	$ 162,900			$ 9,950	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 450,000	$ 162,900			$ 9,950	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ O** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Elms **#** 0021568 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Elms COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0021568

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,100 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Site (acres)	7	1975	$ 49,000	1
2					2
3	TOTALS	7		$ 49,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1977	1976	$ 1,995,722	$ 39,914	50	$ 39,914	$	$ 1,124,257	4
5	Building		1978	1978	30,054	601	50	601		16,830	5
6	Building		1980	1980	186,829	3,737	50	3,737		94,009	6
7	Building		1981	1981	32,336	647	50	647		16,115	7
8	Storm Sewers		1977	1977	77,642	2,588	50	2,588		72,983	8
	Improvement Type**										
9	Storage Building E			1978	15,445		20			15,445	9
10	Road & Parking Lot E			1978	27,033		25			27,033	10
11	Rock for Driveway E			1979	2,381		10			2,381	11
12	Doors/Storage Building E			1980	320		10			320	12
13	Furnace/Storage Building E			1980	652		15			652	13
14	Bathroom Heaters			1981	4,342		10			4,342	14
15	Annunciator Panel			1981	1,867		10			1,867	15
16	Fire Sprinklers			1981	1,455	58	25	58		1,453	16
17	Energy Management System			1982	18,400		20			18,400	17
18	Tile			1982	2,956		10			2,956	18
19	Dietary Remodeling			1982	26,152	872	30	872		19,179	19
20	Lighting Fixtures			1982	303		10			303	20
21	Dietary Remodeling			1983	270,793	9,026	30	9,026		198,581	21
22	Windbreak			1983	950	32	30	32		698	22
23	Tile			1983	2,092		10			2,092	23
24	Parking Lot Lights			1983	5,100		20			5,100	24
25	Road E			1983	24,963	999	25	999		22,967	25
26	Air Handling Unit			1985	6,100	102	20	102		6,100	26
27	Exhaust Fan			1985	2,473		10			2,473	27
28	Transformer			1985	1,675		10			1,675	28
29	Ceiling Tiles			1986	457		10			457	29
30	Compressor			1986	1,391		15			1,391	30
31	Generator			1987	1,557	78	20	78		1,422	31
32	Ceiling Tiles			1987	1,540		10			1,540	32
33	Exchange System			1988	7,622	381	20	381		6,573	33
34	Driveway Paving			1988	12,172	609	20	609		10,502	34
35											35
36	TOTAL (lines 4 through 35)				2,762,774	59,644		59,644		1,680,096	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Storm Sewer		1978	1978	$ 5,078	$ 169	30	$ 169	$	$ 4,739	4
5	Landscape		1977	1977	24,326		20			24,326	5
6	Landscape		1978	1978	15,382		20			15,382	6
7	Landscape		1980	1980	500		20			500	7
8	Landscape		1981	1981	19,864		20			19,864	8
	Improvement Type**										
9	Asphalt Parking Lot			1988	33,039		15			33,039	9
10	Holby Tempering Valves			1989	2,530		10			2,530	10
11	Energy Management System			1989	16,500	825	20	825		13,269	11
12	Control Panel			1989	3,400	170	20	170		2,735	12
13	Driveway Improvements			1989	1,152	57	20	57		968	13
14	Ceiling Fans (4)			1990	3,600		15			3,600	14
15	Nurses Station			1990	4,659	233	20	233		3,687	15
16	Energy Management System			1990	16,363	818	20	818		12,763	16
17	Paint/Wall Covering/Bath			1991	7,387	369	20	369		5,506	17
18	Wall Covering N & S Corridor			1991	9,407	470	20	470		6,974	18
19	Painting/Labor			1991	2,600		10			2,600	19
20	Drywall/ N & S Corridor			1991	10,800	540	20	540		8,008	20
21	Tempered Glass			1991	4,787	239	20	239		3,469	21
22	Additional Wall Covering N & S Corridor			1991	7,018	351	20	351		5,057	22
23	Roof Repair			1991	43,249	2,163	20	2,163		30,817	23
24	Repair Sidewalk			1991	1,030	52	20	52		735	24
25	Roof Repair			1991	27,243	1,362	20	1,362		19,069	25
26	Water Heater			1992	3,300		10			3,300	26
27	Water Heater			1992	3,150		10			3,150	27
28	Fire Alarm/Smoke Detector			1992	504		10			504	28
29	Fire Alarm/Smoke Detector			1993	2,921		10			2,921	29
30	Cubicle Curtains			1993	22,395	1,493	15	1,493		19,285	30
31	Driveway			1993	2,010	101	20	101		1,224	31
32	Carpet			1993	1,710		6			1,710	32
33	Compressor			1994	350		10			350	33
34	Nurses Stations			1994	1,042	52	20	52		616	34
35	Water Heater			1994	5,645		10			5,645	35
36	TOTAL (lines 4 through 35)				302,941	9,464		9,464		258,342	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Landscape		1982	1982	$ 318	$		$	$	$ 318	4
5	Building		1982	1982	8,500	170	50	170		4,080	5
6	Landscape		1984	1984	449					449	6
7	Landscape		1984	1984	1,486					1,486	7
8	Storage		1989	1989	29,469	1,473	20	1,473		23,574	8
	Improvement Type**										
9	Energy Management System			1995	8,325	416	20	416		4,370	9
10	Handrails			1996	750	37	20	37		367	10
11	Tile Flooring			1996	374	38	10	38		357	11
12	Carpeting			1997	2,240		6			2,240	12
13	Dormer Repair			1997	8,046	402	20	402		3,385	13
14	Emergency Arcing			1997	2,659	266	10	266		2,238	14
15	Exterior Masonry Waterproofing			1997	3,991	200	20	200		1,648	15
16	Engineering Costs - Underground Storage Tank Removal			1997	3,000	200	15	200		1,633	16
17	Tile Flooring			1998	9,002	900	10	900		7,126	17
18	Soffit & Fascia			1998	9,400	470	20	470		3,682	18
19	Heat Pump Compressors			1998	2,637	264	10	264		1,957	19
20	Overhead Heat Pump			1998	672	67	10	67		481	20
21	2 L-Shaped Counter Tops			1999	1,300	65	20	65		444	21
22	Fascia & Ceiling Panels			1999	595	59	10	59		400	22
23	Counter Top			1999	480	24	20	24		160	23
24	2 Counter Tops			1999	640	32	20	32		211	24
25	Vinyl Blinds			1999	757	51	15	51		317	25
26	Painting - Resident Rooms			1999	25,856	2,586	10	2,586		16,808	26
27	Painting - N & S Lounges			1999	7,194	719	10	719		4,315	27
28	Carpeting - Nurses Station			2000	579	97	6	97		524	28
29	Roof - Generator Room			2000	500	33	15	33		171	29
30	Grease Pit			2001	3,348	335	10	335		1,340	30
31	Disposer			2002	1,961	196	10	196		751	31
32	Boiler for Steamer			2002	3,519	176	20	176		660	32
33	Resident Walls			2003	1,040	104	10	104		277	33
34	Shelter House			2003	3,628	182	20	182		409	34
35											35
36	TOTAL (lines 4 through 35)				142,715	9,562		9,562		86,178	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Building		1993	1993	$ 16,906	$ 338	50	$ 338	$	$ 3,719	4
5	Building		1994	1994	489,387	9,788	50	9,788		107,666	5
6	Landscape		1994	1994	1,600	80	20	80		920	6
7	Landscape		1994	1994	350		10			350	7
8	Building		1995	1995	101,007	2,020	50	2,020		21,043	8
	Improvement Type**										
9	Resident Door Latches			2004	3,000	300	10	300		398	9
10	Bathroom Guardrails			2005	1,220	111	10	111		111	10
11	Water Heater			2005	3,411	141	10	141		141	11
12	Temp Control System			2005	38,330	798	20	798		798	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 through 35)				655,211	13,576		13,576		135,146	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Landscape		1995	1995	$ 2,719	$ 159	10	$ 159	$	$ 2,719	4
5	Building		1996	1996	479	10	50	10		91	5
6	Landscape		1996	1996	1,505	75	20	75		714	6
7	Building		1997	1997	1,251	25	50	25		208	7
8	Landscape		1998	1998	2,966	148	20	148		1,087	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 through 35)				8,920	417		417		4,819	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Storm Sewer		2001	2001	$ 18,898	$ 630	30	$ 630	$	$ 2,730	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 through 35)				18,898	630		630		2,730	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,891,459	$ 93,293		$ 93,293	$	$ 2,167,311	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 430,416	$ 39,157	$ 39,157	$		$ 271,683	71
72	Current Year Purchases	80,958	9,372	9,372			9,372	72
73	Fully Depreciated Assets	346,307					346,307	73
74								74
75	TOTALS	$ 857,681	$ 48,529	$ 48,529	$		$ 627,362	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2004 Chevy Truck	2004	$ 24,869	$ 4,974	$ 4,974	$	5	$ 9,948	76
77	Staff Transportation	1997 Dodge Van	1997	16,993				5	16,993	77
78										78
79										79
80	TOTALS			$ 41,862	$ 4,974	$ 4,974	$		$ 26,941	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,840,002	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 146,796	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 146,796	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,821,614	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Farmland (5 Acres) 1993	$ 12,427	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 12,427	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable - McDonough County/Macomb Public Building Commission - See page 11 note.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms **#** 0021568 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,268,648	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	356,068		3
4	Supply Inventory (priced at cost)	45,195		4
5	Short-Term Investments	550,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,184		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): IntRec11,307,PropTax283,000	294,307		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,517,402	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	61,427		13
14	Buildings, at Historical Cost	3,124,401		14
15	Leasehold Improvements, at Historical Cost	767,058		15
16	Equipment, at Historical Cost	899,543		16
17	Accumulated Depreciation (book methods)	(2,821,614)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,030,815	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,548,217	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 116,256	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,856		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr'dVac123,074DefPropTax283,000	406,074		36
37	Accrued Provider Tax, Due to County	10,730		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 616,916	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 616,916	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,931,301	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,548,217	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,809,058	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,809,058	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	122,243	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 122,243	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,931,301	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,951,815	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,951,815	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,828	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,828	23
	D. Non-Operating Revenue		
24	Contributions	6,708	24
25	Interest and Other Investment Income***	42,876	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,584	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other - see attached schedule	326,893	28
28a	On-behalf receipts-Farm & Macomb PublicBldgComm	92,354	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 419,247	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,423,474	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	948,686	31
32	Health Care	2,145,760	32
33	General Administration	1,007,385	33
	B. Capital Expense		
34	Ownership	146,796	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	52,604	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,301,231	40
41	**Income before Income Taxes (line 30 minus line 40)****	122,243	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 122,243	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,797	2,010	$ 58,444	$ 29.08	1
2	Assistant Director of Nursing	1,834	2,130	46,975	22.05	2
3	Registered Nurses	20,456	22,919	488,999	21.34	3
4	Licensed Practical Nurses	15,344	17,320	280,417	16.19	4
5	CNAs & Orderlies	72,576	81,501	815,742	10.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,876	2,152	32,643	15.17	9
10	Activity Assistants	6,093	6,822	65,762	9.64	10
11	Social Service Workers	3,570	4,126	62,416	15.13	11
12	Dietician					12
13	Food Service Supervisor	3,661	4,188	60,257	14.39	13
14	Head Cook	5,527	6,090	56,961	9.35	14
15	Cook Helpers/Assistants	8,571	9,616	88,960	9.25	15
16	Dishwashers	7,976	8,861	69,387	7.83	16
17	Maintenance Workers	3,773	4,272	71,498	16.74	17
18	Housekeepers	14,457	16,154	143,171	8.86	18
19	Laundry	4,704	5,372	57,719	10.74	19
20	Administrator	1,909	2,146	69,112	32.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,973	2,278	48,374	21.24	23
24	Clerical	5,848	6,473	70,399	10.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,882	2,110	22,512	10.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,827	206,540	$ 2,609,748 *	$ 12.64	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 4,768	1,3	35
36	Medical Director	12	360	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,200	10,3	39
40	Physical Therapy Consultant	25	1,517	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	628	11,3	44
45	Social Service Consultant	18	895	12,3	45
46	Other(specify)				46
47	Computer Consultants	62	3,100	19,3	47
48					48
49	TOTAL (lines 35 - 48)	298	$ 12,468		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charles Ackers	Administrator	N/A	$ 69,112
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,112

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson LLP	Auditing	$ 10,340
Timbuktech	EDP Consulting	3,100
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 13,440

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 251,530
Unemployment Compensation Insurance	24,089
FICA Taxes	191,906
Employee Health Insurance	452,432
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	145,417
Employee Physicals	4,760
Employee Benefit Reimbursement	(176)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,069,958

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,126
Health Care Worker Background Check	750
(Indicate # of checks performed 62)	
County Nursing Home Association	950
Illinois Health Care Association	5,400
Long Term Care Nurses Association	35
Dietary Manager Association	122
SAMS 30, MES/HPSI 175	206
Less: Public Relations Expense	(3,419)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,170

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,608
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,608

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/04 Ending: 11/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule F, Page 21**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,329** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **52,604**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,828**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **See Attachments, Page 25**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.